Appendix M: Medicare Crossover Claim Payment Methodology

Crossover Payment Methodology
Professional Services (CMS-1500, 837P)
Refer to WAC 182-502-0110

- Medical Assistance compares the Medical Assistance allowed amount to Medicare's allowed amount for the service, selects the lesser amount of the two, then deducts Medicare's payment from the amount selected.
- If there is a balance due, Medical Assistance pays the client's cost sharing liability (deductible, coinsurance, or co-pay) up to the lesser of the allowed amounts.
- If there is no balance due, Medical Assistance does not make any crossover claim payment because Medicare's payment exceeds the lesser of the allowed amounts.

The Agency cannot make direct payments to clients to cover the client's cost sharing liability (deductible, coinsurance, or co-pay) amount of Part B Medicare claim. The Agency **can** pay these costs to the provider on behalf of the client when:

- The provider **accepts** assignment; and
- Total reimbursement to the provider from Medicare and the Agency does not exceed the rate in the Agency's fee schedule.

Note: The Agency is revising **codes** that may be noncovered by Medical Assistance, but the services are covered. If the service is covered by Medical Assistance, but the code is not, then the Agency may pay as follows:

Medicare Allowed – Medicare Paid = The Agency payment

The Agency payment on crossover claims equals the lesser of the HCA allowed amount minus the Medicare or Part C plan payment toward the client's cost sharing liability. Payment from Medicare or the Part C plan and the Agency cannot exceed the Agency's allowed amount for the service.

- Crossover claim payment cannot exceed the client's cost sharing liability.
- No payment will be made if the Medicare or Part C plan payment exceeds the Agency's allowed amount for the service.

Institutional Services (UB-04, 837I)

Crossover Payment Methodology

Institutional Services (UB-04, 837I)

- Outpatient Hospital
  - Payment equals the lesser of Medical Assistance allowed amount minus the Medicare paid amount up to the client's cost sharing liability (deductible, coinsurance, or co-pay). Total payment to the provider from Medicare and the Agency does not exceed the Agency's allowed amount.

- RHC-Rural Health Clinic
  - For RHCs who bill for Medicare Encounter Services payment equals the Rural Health Clinic (RHC) Per Diem rate on file with the Agency minus the Medicare paid amount. These RHC claims are submitted using Type of Bill 71x and Billing provider Taxonomy 261QR1300X.

- FQHC-Federally Qualified Health Clinic
  - For FQHCs who bill for FQHC Encounter Services, payment equals the Medicare coinsurance amount. These FQHCs bill crossover claims using Type of Bill 77x and Billing Provider Taxonomy 261QF0400X.

- Inpatient Hospital for client with both Medicare Part A and Part B coverage
  - Payment equals **the lesser of** Medical Assistance allowed amount minus the Medicare paid amount, up to the client's cost sharing liability (deductible, coinsurance, or co-pay).

Note: The Agency would adjust any payment amounts if the client has a Commercial Medicare supplement policy (TPL) and that supplement payer makes a payment after Medicare. In that case the formula would be:

Medical Assistance allowed – Medicare Paid – TPL Paid = The Agency payment